Statement of

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on behalf of the

Kaiser Permanente Medical Care Program

at the request of

Aneesh Chopra

Chair, Implementation Workgroup, HIT Standards Committee

Office of the National Coordinator, Health Information Technology

October 29, 2009

Mr. Chopra, members of the workgroup, thank you for the invitation to be here today. I am Dr. Andy Wiesenthal, Associate Executive Director of the Permanente Federation, the national umbrella organization for the regional Permanente Medical Groups, which comprise the physician component of Kaiser Permanente. The Permanente Medical Groups employ more than 14,000 physicians, who care for approximately 8.7 million Kaiser Permanente members in nine states and the District of Columbia.

I appear today on behalf of the national Kaiser Permanente Medical Care Program, which is the largest private integrated healthcare delivery system in the United States. In addition to the Permanente Medical Groups, it includes the Kaiser Foundation Health Plan, Inc. and the Kaiser Foundation Hospitals and their subsidiaries

In 2008, Kaiser Permanente members had 36.7 million provider office visits; 547,338 surgeries; 129 million prescriptions filled; 1.1 million mammograms performed; and 1.6 million colorectal cancer screenings.

We began our Kaiser Permanente HealthConnect project in 2003. Our intent was to deploy an electronic health record across our entire enterprise—ambulatory, emergency, and inpatient settings, along with key ancillary departments, and we have succeeded. The deployment included clinical documentation, order entry and results reporting, decision support, scheduling, registration, and a variety of ancillary system functions, along with a personal health record. The ambulatory and ancillary deployments were completed in early 2008, and only 4 of our 36 hospitals remain to be completed (by the end of the first quarter of 2010). 14,000 Permanente physicians and approximately 150,000 staff use only an electronic health record for all of their work in 431 medical offices and 32 hospitals. Twelve KP hospitals were recognized by HIMSS as Level 7 institutions in early 2009, and there are only 3 other hospitals in the country who have achieved this level of digital integration.

In 2008, 2.7 million unique Kaiser Permanente members used My Health Manager, Kaiser Permanente's online personal health record, which allows patients to securely access their health records from home, as well as e-mail their physicians, refill prescriptions, make, change, and cancel appointments for themselves or for family members, and view lab results, at no extra charge.

Each month, more than 600,000 secure e-mail messages are sent to Kaiser Permanente clinicians, more than 1.6 million lab tests are viewed, and 1.4 million requests for appointments are made via My Health Manager.

In implementing standards-based HIE at Kaiser Permanente, we need to solve for multiple business and clinical problems simultaneously. Our primary goal is to improve the safety and quality of care, which requires managing the exchange of data between Kaiser Permanente and many other health care organizations, including non-Permanente physicians (ranging from solo practices to large groups), hospitals, skilled nursing facilities, reference laboratories, public health authorities, and others. Moreover, we must do this in all the many cities, counties, and states where our members reside and receive care.

One objective is seamless coordination of care for patients who receive some of their care from Kaiser Permanente and some care from other organizations. Essential requirements for external care coordination include interoperability with other entities based on national and international standards for clinical problems and procedures, drugs, lab results, imaging results, allergies, and other defined categories of clinical information.

HITSP standards have been enormously helpful because they promise a consistent basis for the use of SNOMED-CT and HL7 standards across all of our multiple geographies and jurisdictions. A great example of HIT-enabled coordination in a shared-care scenario is our work with the VA through the NHIN.

The same standards needed to support national interoperability are required for clinical coordination or for transfers of care within Kaiser Permanente. Between our care settings, content exchange standards such as HL7 messaging help to move records between clinicians, but a consistent vocabulary based on SNOMED CT is critical for ensuring that clinical documentation such as problems and findings is understood in the correct context and that all patients will benefit from the use of advanced decision support tools ultimately triggered by these data elements.

Another key objective is ensuring the same high levels of patient safety and quality of care in any location at any time. Because we operate in many states and in different jurisdictions, implementing national and international standards is extremely important to us. HIT standards implementation that varies from state to state adds cost and complexity, and it takes resources away from patient care investments and other opportunities, such as funding a more comprehensive EHR. The opportunity cost of variation in HIT implementation should be considered seriously by this Committee. If our long-term national goal is to implement interoperability standards that enable all patients to obtain the quality and safety benefits of HIT, allowing interim variation, even if it seems expedient, will delay and seriously undermine that ultimate goal, reduce efficiency, and increase the total cost of implementing the standards.

Claiming that alternatives to interoperability standards are easier to implement is not only misleading, it can increase patient safety risks and create new disparities of care. The HITSP interoperability standards, already required for FEHB carriers and Medicare Part C and D plans, ensure data integrity and transparent traceability to an original source. Alternative solutions do not. They lack features to guarantee electronic document integrity, do not use globally unique identifiers and do not maintain the electronic signature as the HITSP and NHIN standards do. As a clinician, I am more likely to use data I can trust. When data comes from an HIE or a PHR or any other source less reliable than a valid clinical record source, then the patient could potentially be disadvantaged because that patient's record cannot be objectively evaluated for data quality and data integrity. In a paper record world, clinician suspicion about the reliability of information is a primary driver of redundant tests and procedures—widely recognized as costly and unsafe. It would be tragic to miss the chance to improve the trustworthiness of data by failing to appropriately standardize HIE, thereby perpetuating this damaging practice in an EHR world.

Our greatest success may be the full implementation of care coordination via the NHIN, starting with federal partners like the VA and using the standards already recommended for Meaningful Use. Currently, we have identified a large population of patients in a shared care situation as a pilot group. These patients are veterans who now receive their private sector care from Kaiser Permanente. On multiple occasions last year

we demonstrated to the then-Secretary of HHS and the Secretary of the VA the ability of our production-ready systems to exchange CCDs via the NHIN. Earlier this year, we performed a public demonstration of those same interoperability capabilities with several fully operational HIOs in California. Some, like the rural HIO in Mendocino, stood up their own gateways using the NHIN Connect open-source software, on a shoestring budget in a matter of a few weeks—and the technology worked. The Mendocino demonstration allowed a new HIE vendor to showcase the relevance of the CONNECT software as an agile tool for the broad market. Other HIOs like Santa Cruz got a fully integrated NHIN gateway from their vendor—and that works for them. The Santa Cruz HIE showed how an existing HIE vendor using their commercial NHIN gateway could connect with several NHIN gateways following the federal standard and successfully exchange data. These approaches represent alternatives in an emerging marketplace for NHIN connectivity options. The NHIN will represent a success for standards implementation in achieving the benefits of HIT. One of the main benefits of the common approach to interoperability standards evident in the NHIN is that the HIT and HIE solutions are reproducible everywhere.

Our frustrations in implementing standards in HIT and HIE are common to all clinical HIT projects—competition for scarce technical and investment resources within HIT, and difficult decisions about investing human and capital resources in HIT versus other projects or initiatives with more rapid or direct clinical impact. Consistent local, state, or federal support for the planning, implementation, and training related to interoperability standards could mitigate these problems and accelerate adoption. If the HIT workforce is trained on a wide variety of HIE standards alternatives, this could result in lower data integrity of the clinical records being exchanged—and scarce resources will be further diluted. It will take much longer and ultimately be more costly to achieve the same benefits in clinical safety and outcomes. The other major factor to address is funding standards implementation. Getting the Meaningful Use incentive payments out to hospitals and physicians will be enormously beneficial in accelerating adoption. I cannot resist the opportunity to point out here that our health care system is poised to spend billions on a conversion from ICD-9 to ICD-10 that is unlikely to have any clinical impact whatever. If this money were instead spent on converting to SNOMED-CT, with formal maps to the various classification schemes (including ICD-10) in the background, we will have advanced clinical care and achieved the same desired changes to financial systems.

In sum, HIT/HIE standards will have the greatest impact on our members and patients in the quality of clinical data available to providers and the ability to use that high quality data to improve health care delivery, health outcomes, and patient safety. With consistent adoption and implementation of these standards, the substantial benefits of HIT and HIE will be realized more rapidly by most clinicians and patients.